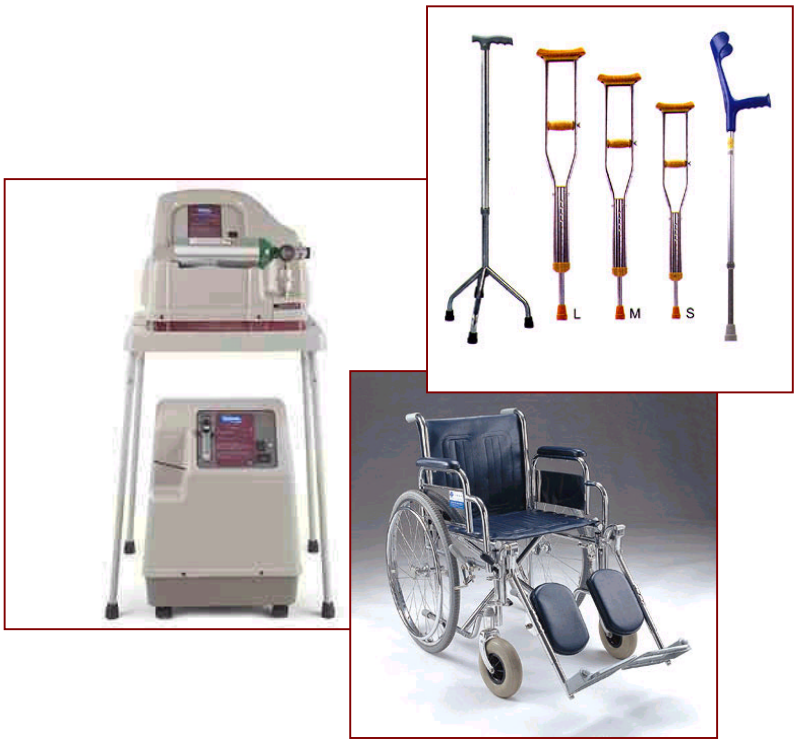
Internal Audit Report

MIHS Contract
Durable Medical Equipment
July 2003



Audit Team Members

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July 31, 2003

Fulton Brock, Chairman, Board of Supervisors
Don Stapley, Supervisor, District II
Andrew Kunasek, Supervisor, District III
Max W. Wilson, Supervisor, District IV
Mary Rose Wilcox, Supervisor, District V

We have completed our FY 2002-03 review of the Maricopa Integrated Health System (MIHS) contract with Western Medical, Inc. for durable medical equipment (DME). The audit was performed in accordance with the annual audit plan that was approved by the Board of Supervisors.

The highlights of this report include the following:

- MIHS' current claims processing system cannot distinguish between capitated rate claims and "Fee for Service" claims, which exposes the County to financial risk.
- Some payments made to Western Medical were missing required authorizations, which increases the risk of payments being made to the contractor for inappropriate time spans and/or inappropriate equipment.
- Our testing of previous system generated claims payments detected price discrepancies between the contract's vendor price schedules and claim payment amounts. This control weakness exposes the County to financial risk.

The report summary, detailed findings, recommendations, and MIHS management's response are attached. We have reviewed this information with the MIHS Director of Claims and appreciate the cooperation provided by management and staff. If you have questions, or wish to discuss items presented in this report, please contact Eve Murillo at (602) 506-7245.

Sincerely,

Ross L. Tate

Ross L. Tate
County Auditor

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Executive Summary

MIHS' automated payment systems, bill processing procedures, and durable medical equipment (DME) contract oversight activities are not adequate to detect overpayments and unauthorized billings. These control weaknesses contributed to DME contract overpayments, exposed the County to legal risk, and prevented MIHS from effectively managing DME costs. MIHS should strengthen controls over the claims payment process.

Introduction

Background

Physicians often prescribe special equipment to be used by beneficiaries in their home. The equipment may provide therapeutic benefits or enable the person to perform certain tasks that he/she is unable to undertake due to certain medical conditions and/or illnesses. The following are commonly used durable medical equipment (DME) items: diabetic supplies, canes, crutches, walkers, commode chairs, home oxygen equipment, hospital beds, power operated vehicles (POVs or scooters), seat lift mechanisms, traction equipment, and wheelchairs. The DME items primarily serve a medical purpose that can withstand repeated use, is appropriate for home use, and generally useful for a person with an illness or injury. Maricopa Integrated Health System (MIHS) contracts with Western Medical to provide DME items.

The County contract between Western Medical and MIHS took effect in August 1998 and expires August 2003. MIHS will then develop a request for proposal for a future DME contract. The Not to Exceed (NTE) amount of the current contract is $8.3 million, which represents the total amount of reimbursable services that MIHS may pay to Western Medical. As of May 14, 2003, the total amount of cumulative payments from contract inception was $7.8 million.

Western Medical supplies custom and non-custom DME items to MIHS patients. Custom DME equipment is any item that has been modified for use by a specific individual. Examples include wheelchairs, beds, and padding. This equipment is billed and paid via “Fee For Service” reimbursement rates that are negotiated on an annual basis. Western Medical is required to annually submit a “Fee For Service” schedule for all custom DME equipment that the company provides. This schedule should include the equipment’s corresponding procedure code, description, sale price, reimbursement price, and its six-month maintenance fee.

Maricopa Managed Care System (MMCS) Authorization Policy and Procedures require all “Fee For Service” DME to have an authorization issued by MMCS Medical Management. These authorizations state the type of equipment the patient may use and the time period. Authorizations are used both for a medical usage time frame and a payment time frame. Claims processors are instructed to process “Fee For Service” equipment only when authorization date ranges are valid.

Authorizations are maintained within the claims system and each authorization should be referenced in the claim detail.

Non-custom equipment can be used by the general population without modification and includes items such as oxygen services, blood pressure equipment, bed mattresses, IV stands, and bandages. These items are charged on a capitated basis; one base rate is charged per patient per month regardless of how many non-custom items the patient has in their possession.

Scope and Methodology

The objectives of this audit were to determine if:

- Western Medical has fulfilled its contract obligations to the County
- Contractor invoices and billings are adequately documented and do not exceed the rates/amounts specified by the contract
- County payments do not exceed contract rates/amounts
- MIHS adequately monitors Western Medical's performance and compliance with contract terms and conditions

NOTE: We tested DME contract payments, made to Western Medical from July 2001 through October 2002, generated by MIHS' INC payment processing system. MIHS replaced this system with the OAO payment processing system in November 2002. While attempting to test payments processed through the OAO system, we encountered a system limitation that prevented testing. This system limitation is discussed in this report.

This audit was performed in accordance with generally accepted government auditing standards.

Issue Contract Oversight

Executive Summary

MIHS' automated payment systems, bill processing procedures, and durable medical equipment (DME) contract oversight activities are not adequate to detect overpayments and unauthorized billings. These control weaknesses contributed to DME contract overpayments, exposed the County to legal risk, and prevented MIHS from effectively managing DME costs. MIHS should strengthen controls over the claims payment process.

Payment Types

Our review of MIHS' new claims payment system (OAO) found that the system does not distinguish between Fee for Service (FFS) and capitated payment rates, unlike the previous system (INC). OAO lacks a coding field for this important data. As a result, in March 2003 MIHS realized that capitated claims, paid from November 2002 to March 2003, had been reimbursed at the somewhat higher FFS rates. NOTE: MIHS is currently assessing and correcting any excess payments.

Another consequence of OAO's coding control weakness is that information on capitated payments to Western Medical has not been submitted to the Arizona Health Care Cost Containment System (AHCCCS) for Medicaid patients. This control weakness increases the risk of non-compliance with the AHCCCS requirement for timely submitted medical services information (encounter data).

Missing Authorizations

MIHS requires that all FFS payments include authorization from the Maricopa Managed Care System Medical Management. We tested 15 payments made to Western Medical and found that five (33%), processed through the INC system, were missing required authorizations. The payments were processed due to claims processor oversight error. The lack of authorizations could result in payments being made to Western Medical for inappropriate time spans and/or inappropriate equipment.

MIHS also does not analyze whether the FFS rental payments to date have exceeded the purchase price for the equipment in question. As a result, MIHS may end up paying rental charges for items well in excess of the outright purchase price.

Although we noted these conditions in connection with reviewing the INC system, the possibility exists that payments processed by the OAO system are also missing authorizations and effective cost analysis. As we previously noted, we were unable to test OAO claims because the system does not distinguish between capitated and FFS payments.

Price Discrepancies

Our testing of INC system generated claim payments also detected price discrepancies between the contract's vendor price schedules and actual claim payment amounts paid through the INC system. Invoices for three (20%) of the 15 payments tested were found to differ from the contract amounts. This control weakness exposes the County to financial risk. Payments processed by the OAO system may also include price discrepancies.

Recommendation

MIHS should:

A. Investigate opportunities to modify the OAO system in order to properly process DME contract payments according to established FFS and capitated rates.

B. Establish controls to ensure that DME contract payments cannot be processed without required authorizations.

C. Investigate payment discrepancies identified in this audit and systematically review claims payments systems for pricing accuracy.

D. Recover any overpayments made to the contractor.

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Department Response

MARICOPA
HEALTH SYSTEM
Count on us to care.

Maricopa Integrated Health System

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DATE: Monday, July 14, 2003

TO: Ross Tate – Internal Audit

FROM: Pat Walz

SUBJECT: **Contract Audit Report of Western Medical July 2003**

Attached is our response to the four part audit recommendation as reported in the audit dated July 2003. The issues noted related to authorizations and lack of tracking mechanisms were known to the management of the Health Plans. These issues were some of the reasons for moving from the INC processing system to the OAO processing system.

Thank you for this opportunity to improve our service and provide a positive return to Maricopa County.

Issue # 1: Contract Oversight

MIHS' automated payment systems, bill processing procedures, and DME (Durable Medical Equipment) contract oversight activities are not adequate to detect overpayments and unauthorized billings. These control weaknesses have contributed to DME contract overpayments, exposed the County to legal risk, and prevented MIHS from effectively managing DME costs. MIHS should strengthen controls over the claims payment process.

Response: Concur.

Recommendation A: Investigate opportunities to modify the OAO system in order to properly process DME contract payments according to established FFS and capitated rates.

Response: Concur – in process. For a point of clarification, FFS claims are paid from OAO and capitation is paid from STAR. Capitation claims are processed through OAO for the purpose of encountering the service to regulatory bodies. This dual capitation/FFS arrangement with this provider necessitates a provider file for each arrangement. The dual provider files were set up on June 13, 2003 and claims began to be directed to the appropriate provider number at that time.

MIHS will review the accuracy of payments made to Western Medical for the period October 27, 2002 to June 13, 2003. Any overpayment will be recovered.

Target Completion Date: August 15, 2003.

Benefits/Costs: Enhanced profitability.

Recommendation B: Establish controls to ensure that DME contract payments cannot be processed without required authorizations.

Response: Concur – completed. All DME claims require a prior authorization and the HCPCS codes for DME procedures are configured to automatically search for a prior authorization. If an authorization is not found, the claim is pended for manual processing. Some of the claims tested by internal audit were for services billed under E1399 (miscellaneous DME) which does not require a prior authorization.

Target Completion Date: Not applicable.

Benefits/Costs: Enhanced profitability.

Recommendation C: Investigate payment discrepancies identified in this audit and systematically review claims payments systems for pricing accuracy.

Response: Concur – completed. A letter detailing discrepancies between paid and contracted amounts was sent to Western Medical on June 25, 2003. The letter directed the vendor to issue a check payable to MIHS in the amount of $116,931.14.

With regard to pricing accuracy, this dual capitation/FFS arrangement with this provider necessitates a provider file for each arrangement. The dual provider files were set up on June 13, 2003 and claims began to be directed to the appropriate provider number at that time.

Target Completion Date: June 13, 2003.

Benefits/Costs: Enhanced profitability.

Recommendation D: Recover any overpayments made to this contractor.

Response: Concur – completed. A letter detailing discrepancies between paid and contracted amounts was sent to Western Medical on June 25, 2003. The letter directed the vendor to issue a check payable to MIHS in the amount of $116,931.14.

Target Completion Date: Letter sent June 25, 2003; recovery to be determined.

Benefits/Costs: Enhanced profitability.

Approved By:

Department Head/Elected Official	**Date** 7/14/03
Chief Officer	**Date** 7/15/03
County Administrative Officer	**Date** 7/20/03

Auditor Comments to MIHS Response

Issue #1, Recommendation B – Establish controls to ensure that DME contract payments cannot be processed without required authorization.

MIHS' response states that some of the claims tested by Internal Audit were for E1399 services which do not require prior authorizations. However, our audit testwork shows that none of the auditors' test claims were for E1399 services.